No. 300
10-48

FILED OCT 4 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33721

BIRTH NO. 66111 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 547 Registrar's No. 9426

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1. PLACE OF DEATH
a. COUNTY ST. LOUIS ~~ST. MARYS HOSPITAL~~
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RICHMOND HEIGHTS
c. LENGTH OF STAY (In this place) 16 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. MARYS HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE MISSOURI
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) CITY ST. LOUIS LA. 2159
d. STREET ADDRESS (If rural, give location) 5301 GILSON 16

3. NAME OF DECEASED (Type or Print) a. (First) BABY b. (Middle) MATTINGLY c. (Last)

4. DATE OF DEATH (Month) (Day) (Year) 9-17-52

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE
8. DATE OF BIRTH 9-17-52
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 16 45

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
10b. KIND OF BUSINESS OR INDUSTRY NONE
11. BIRTHPLACE (State or foreign country) ST. MARYS HOSPITAL
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME BARNEY MATTINGLY
13b. MOTHER'S MAIDEN NAME MAYDEAN NULL
14. NAME OF HUSBAND OR WIFE SINGLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT'S SIGNATURE OR NAME BARNEY MATTINGLY ADDRESS 5301 GILSON

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity 26 Wks.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pulmonary Atelectasis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. 7625

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-17-52 *19* ___ *to* 9-17 *, 19*52*, that I last saw the deceased alive on* 9-17 *, 19*52 *and that death occurred at* 10:25 *p.m., from the causes and on the date stated above.*

23a. SIGNATURE Thomas Mier MD (Degree or title)
23b. ADDRESS 607 N Grand
23c. DATE SIGNED 9-20-52

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9-19-52
24c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery
24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.

DATE REC'D BY LOCAL REG. 9-19-52
REGISTRAR'S SIGNATURE Herbert R. Domke M.D.
25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis ADDRESS 2906 GRAVOIS

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed Homer C. Dill

Signed.....
Student Embalmer

Licensed Embalmer No. 4347

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.